

Vocabulary Task Force
Draft Transcript
June 29, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to the Vocabulary Task Force Call. This is a federal advisory committee, so there will be opportunity at the close of the call for the public to make comment. Let me do a quick roll call of members. Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Clem McDonald? Stuart Nelson?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rowland? John Halamka?

Marjorie Rowland

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

I know Marjorie is here. John Halamka? Stan Huff?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Chris Chute?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marc Overhage? John Klimek? Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Trudel? Don Bechtel? Patricia Greim? Andy Wiesenthal? Bob Dolan? Lisa Carnahan? Nancy Orvis?

Eric Strom – DoD Military Health System – Program Management Support

Eric Strom for Nancy Orvis.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Nancy Orvis is present.

Judy Sparrow – Office of the National Coordinator – Executive Director

There's two of your. Marjorie Greenberg? Did I leave anybody off? With that, I'll turn it over to Jamie and Betsy.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thanks very much, Judy. Hello, everybody, and thank you for your time today. The purpose of this call and our sole agenda item, as we discussed last time, is to discuss the planning for one or more hearings on vocabulary infrastructure we had discussed starting with getting testimony, a variety of viewpoints on repositories, and following our last set of recommendations around repositories, we wanted to try to have a structured discussion today to talk about the scope of things that we wanted to ask questions about for this hearing. Now there is a one-page slide that I think, Judy, if you could go to that on the Web screen.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. Alison, can you get that?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

It's also downloadable here. Is there anybody who cannot see that slide?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Hello. This is Marjorie Greenberg.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Hello, Marjorie.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I was a minute late there.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I put together this matrix just as a draft for us to have something to help structure our discussion. As you can see, I'd listed down the left-hand side a number of possible functions of this kind of repository infrastructure and then the columns going across are different ways in which those functions may be used for value sets versus subsets versus entire vocabularies, interface terminologies, and cross maps. And so I think, at the end of the day, the objective for this particular call is to agree on a scope for the upcoming hear or hearings and to start to draft questions that we want to ask our witnesses.

In the first place, I wanted to get feedback from everyone on the line about the matrix itself. Does this make sense as a way to approach this? And then how could, or if it does, or I guess if it doesn't, what else could we use? And if it does, how could it be improved for this purpose?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Jamie, this is Chris Chute. I actually think this is a very good beginning, and obviously crosswalks functionality against the objects that you'd be functioning on. I might urge you to look at the HL-7 specification on terminology services that actually enumerates a lot of these functions and gives more detail as to what that might be. There might be some overlap or dissidence in that I think the terminology services specification is a bit more general than what you've enumerated here, and there is advantage to counting down to just what we need, but I wouldn't want us to overlook that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

A good suggestion; obviously I didn't start there.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I just had a question of what you're thinking of in terms of interface terminologies as opposed to the base standards. Do you have a specific set of things that you think of as interface terminologies exclusively?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I'm thinking of what we would internally call alternate display names.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I'm wondering if that should be on the left-hand side, and then you put X's, you know, that you're going to do that kind of thing for value sets and base standards.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

How do other folks feel about that?

Marc Overhage – Regenstrief – Director & Research Scientist

Well, in the terminology services model, Jamie, the display format is an attribute of a term, and a term, Stan is quite right. A term can be within a value set. It can be a subset of a base standard, etc. It's not so much a freestanding thing, as it is an attribute of those other things, so it is more a function than a discrete target.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Anything else? Is there anything else?

Marc Overhage - Regenstrief – Director & Research Scientist

I'm having trouble getting on to see it, so I don't know what I'm responding to. Okay. I'm having success now.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I would just second what Chris said though initially that I think this is a good way to explain it, and I think it answers or at least makes explicit that we're thinking about supporting. We're thinking about a different level of support and capability for value sets and subsets than what we're thinking of, than what we're biting off in terms of base standards.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Obviously that's one of the flavors that I wanted to capture by putting different X's in here, which we can now also see how folks feel about whether the first stab at this is in the right direction or not.

Marc Overhage – Regenstrief – Director & Research Scientist

With that being said, I guess I would quibble a little bit in that you're still going to have to contend with version management on the base standards. I mean, ICD-9 CM does change X times a year, and that's a base standard, and version management will need to be accommodated. Therefore, you get into all the issues of content management and conceivable storage management associated with the base standards as well.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Well, I think it's – yes. I want to agree and disagree a bit. You have to worry about the fact that there's a new LOINC version coming or a new SNOMED coming, and you have to accommodate multiple copies on the distribution. But I think you don't have to, or at least I didn't think we were committing to say that means that we have to make the change set between two versions of LOINC, or we have to, you know, I really don't think we'd get into content management. We have version management in the sense that we need it for those base standards is the simpler thing than what I think is implied by for the value sets and subsets where we're actually really maintaining the content.

Marc Overhage – Regenstrief – Director & Research Scientist

Could someone explain the difference between the value set and a subset briefly?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Generally, the way we've been using those terms is that the value set is the universe of terms, concepts, and other things that may be useful, for example, for constructing a particular quality measure or for any particular purpose. Whereas a subset is usually a frequency distribution based subset. It's more for the convenience of an implementer. It may be a subset that's frequently used for a particular specialty or for a variety of reasons. Most commonly ordered lab tests would be or reported in HETUS is an example that we've used before.

Marc Overhage – Regenstrief – Director & Research Scientist

I have trouble holding onto this. It's a slippery slope between those two. Is there any use to have the same set of choices, X's on them, is there any need? It's not a sharp line.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think that there may be differences, and I don't know, Floyd, if you want to speak to the creation of value sets in the measure world, but there may be different owners, potentially even different licensing issues for some of the value sets. Where a subset is within one vocabulary, a value set may include terms and concepts for multiple vocabularies, so that's, I think, a clear, differentiating factor.

Marc Overhage – Regenstrief – Director & Research Scientist

Do either of these tie to specifically defined fields or questions so that one can really anchor them?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. That's my area of interest. All of these things, in defining the value sets, that's really part and parcel of what we're doing. When you say the value set, you have to say this value set is intended to be used with this data structure or with this information model, however you think of those terms. That has to be part of the definition so that you say this value set is intended to be the orderable drugs in pharmacy orders, or this is the allowable route or routes of administration. So there has to be that tie because that's really the only way that you get to a precise definition is to know exactly the message and information context in which this thing is used.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. This is Floyd. That's the experience we're having in the measure retooling is, it's not just a set of values for any specific concept, but understanding where it's being used. One example that came up was a great example is for a pacemaker to know that it is in place. It's insitu is often identified as a condition to know that it's a device that is a procedure to place it is a different set of terms, and that was one that came up in one of the measures. There are a number of others. But the values themselves are the value set. The context has to be applied to it.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I think that without context, you often don't know what you're talking about, even though it looks like you are when you see these few standing things.

Betsy Humphreys – National Library of Medicine – Deputy Director

This is Betsy. I do think the big distinction is that a value set is defined. It's the universe of values for a particular purpose and that's it. You can only use these values for that particular purpose.

Clem McDonald – NIH

Does it have an administrative or legal touch? That would help clarify to me if there was.

Betsy Humphreys – National Library of Medicine – Deputy Director

You know it's interesting because way back at the beginning of this group, I attempted to put down definitions of value set and subset just for this reason. And I guess we aren't successful in carrying these over from one call to the next, but I do think that in this, I believe I'm correct that in this context, what Jamie meant by value set was where we define for a particular purpose the universe of values that are going to be used, either to define something or the only set that can be in that piece of the message that is defined for this particular purpose, whereas a subset, as he said, is for convenience.

Clem McDonald – NIH

And the other question about subset, generally a subset is something from a bigger set.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. Those subsets are subsets of a value set.

Clem McDonald – NIH

Only a value set from that base standard?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Right. Well I guess, yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

No, the subsets are subsets of the base standards.

Clem McDonald – NIH

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

And obviously a value set can be a true subset, and also a value set could be the universe if we had a base vocabulary where you said the value sets of this is any LOINC orderable. It could be the whole....

Clem McDonald – NIH

A star below this diagram just saying with a short sentence, I think a value set is a formally defined, specified list for a purpose. That's what I'm hearing.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. Another word I would throw in there is that, if you will, it's the normative set, which goes back to what everybody has been saying. But it is, if you will, it's the thing that provides the enforceable, and I don't know if we enforce things or not. Maybe normative is the better word, which means people still have a choice. But what it's saying is this is providing the allowed set of codes in this context, and at least one meaning of the subset, for instance, is that you can context that more narrowly in another, more specific use case.

Say we had a value set for the problem list or for health issues, however you want to think about that. That would be a value set, and you would have, you know, you may have 20,000 or 10,000, whatever we come up with as the normative set of things that are problems. Then you could have a subset, which, within our systems, we have, for instance, we have people who are using those problem lists in the neonatal intensive care unit, or we have another application where we maintain problems for people who are doing pediatric cardiac catheterization, so pediatric cardiology. And we make subsets out of that so that in the neonatal intensive care unit, we may now have only a couple of hundred diagnoses. And in the pediatric cardiology, we may have. So to use now they're not normative, but they're very useful because they allow us to make a more convenient user interface for that subset of people that are using it in a very specific context.

Clem McDonald – NIH

Would anyone? The word subset is such a generic term. Could a convenient set work better?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We have described them as convenient subsets.

Clem McDonald – NIH

If you added that, it might help, you know, for the people who kind of come in from the public and other sources.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. But it's not, so I think that convenient subsets also may sometimes denote more optionality than there is, so sometimes a subset, as an example, could be a minimum rather than the universe, as a value set is.

Clem McDonald – NIH

I'd plead for just stars on the words in this two lines below the figures so when we get other participants, they'll remember a very short list.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And I can think of one of the lab results standards that has a requirement for a particular subset as a minimum of the LOINCs that have to be used by implementers.

Clem McDonald – NIH

Then subsets can be a subset of the value set or the base value set. I guess that's a nice definition.

Betsy Humphreys – National Library of Medicine – Deputy Director

Clem, I think your point is if we're going to invite anyone in to talk about this or deal with this in the future, we just need to be sure that we don't hand them something without a definition of these terms.

Clem McDonald – NIH

Yes, a nice, short.... I think I heard two of them that were pretty clear, but I didn't write them down.

W

We don't have someone taking semantic minutes?

Clem McDonald – NIH

Well, could I just – it's a comment, and I think this is an extremely ambitious undertaking. I don't know where we really are hoping to get to given the current sort of difficulty with sort of simpler things that are being proposed.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I guess I would agree, but....

Clem McDonald – NIH

It doesn't mean we shouldn't try it, right?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes, yes. That's where I was going is that I hope we don't think we have to be done with it before it would be useful. In other words, if you make one useful value set, then it's one useful value set. And it may take us a long time to get sort of all useful value sets done.

Clem McDonald – NIH

What will change? What's useful will change too, and what what's added to them will change.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

But, I mean, I don't see any simpler or any simpler way to do this that would meet the goal we have to really make data exchange and measure definition of sharing of decision support logic possible than to do this. I mean, if you have a better way to do it, then I would love to hear that.

Clem McDonald – NIH

A better way, one better, well, it's not a better way. I mean, the key thing is that people would use the codes that always come from a universe that everybody understood.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let's get back to the purpose of this call, which is to organize our thinking around one or more hearings that we're going to have that we're going to hold on repository infrastructure. So I think what I've heard is that this is a good way to think about it. We want to refine this, perhaps refer to the HL-7 terminology services, at least do a crosswalk for a future discussion, have that understanding. We want to reconsider the placement of interface terminologies, but now if this is – is this about the right scope where the X's are, or are there – I mean, I did hear that we need to consider version management for the base standards of the entire vocabularies. Are there other things in terms of the scope that's indicated by the X's that folks would like to change? This was just a first draft that sort of I threw out there for discussion, frankly.

Clem McDonald – NIH Scientist

I think there are some other dimensions of vocabulary management in a repository. That is, is this assumed to be a place where people could put stuff or must put stuff? Is it a place where people could find things, but they could still go to the original source? Is it a place where we assume everything from the original source will be available in this source? So there are some other aspects of it, and then is there any assumption about timing that'll be there simultaneously with the distribution from another source, the original source? I mean, is this sort of an adjunct that's going to help things along, or is it the big mojo that's going to do it all?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think the request from our previous witnesses, and particularly from the provider community and the vendor community of EHRs or users is they want one stop shopping for the things that they have to use for meaningful use. That's the gist of it. And so, in the first place, it's not everything for every purpose. It's for purposes related to achieving the meaningful use incentives. And then the idea is not to replace whatever else exists, but that this should, I think, assist the process and be a place where you could go to at least get pointed in the right direction in terms of the base standards or that you could actually get downloads. Now I think, Clem, you raised a very interesting question about whether the repository should have a function for folks to keep their own subsets and value sets, as an example, that they may devise on their own.

Clem McDonald – NIH

Or may offer up to the world via that mechanism.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

Clem McDonald – NIH

When you comb this down to have the value sets that are needed, required for these processes, it's a lot more realizable. When I see the cross maps, didn't I just heard that we've got a cross map between ICD-9 and ICD-10, but no one trusts it or something like that, or it's been advised not to use it?

Betsy Humphreys – National Library of Medicine – Deputy Director

No. I think that's a – I can't agree with that statement.

Clem McDonald – NIH

Well, I want to know, is this cross map feasible always. That's really what the question is.

W

Betsy and Clem, I know that our internal people, for instance for us, are not sure that they will actually use that mapping.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let me perhaps give a different example of cross maps within the context of meaningful use, and that is, I think the IFR indicated, the IFR for standards indicated a direction that initially medication history had to be reported using any of the vocabularies contained within RxNorm and then, in the future phase, that would be transitioned to RxNorm itself.

Clem McDonald – NIH

That's a good example.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So I think that's a case where cross maps would be used within the context of meaningful use where we would want to have this, and I think there is something that could be defined within that purpose. I don't think that it's in scope for meaningful use to have ICD-9 to ICD-10 conversions facilitated.

Clem McDonald – NIH

Yes. I guess the question is cross maps may raise expectations because there are some places where it works well, some places it works with difficulty, and some places it might not work at all. That's all right though. I mean, I agree with what you've just said.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. I guess I'll always thinking this implied is that if by whatever process we decided that a certain cross map like the one that Jamie just described was useful, then it would end up in the repository with those functionalities. It wasn't implying that there was some sort of universal Rosetta Stone for all terminologies or something like that.

Clem McDonald – NIH

No, I agree with that, and cross maps are difficult on the other hand, and I endorse Stan's point that the point of discussion here is the functionality and the service, not necessarily which cross maps. That being said, I think we also have to be cognizant that it won't serve the public well if there are a plethora of cross maps out there for different purposes. I think, ultimately, it's within our purview to designate or have designated one preferred cross map for a particular combination of code systems.

For example, the SNOMED ICD thing has been around forever, and the problem is lots of people use lots of different cross maps. If we want interoperable data, it's not going to serve us well if, I don't know, let me pick on Kaiser. Kaiser uses one particular cross map and Mayo uses a different cross map. Surprise, we're going to come up with different codes, and that's not interoperable information.

Marjorie Greenberg – NCHS – Chief, C&PHDS

This is Marjorie, and I don't want to get into the whole thing about the ... equivalence maps. I don't know who it was who said that they weren't going to use them, but actually the health reform legislation does require that the gems be included as a standard, and there will be testimony and discussion about that at the ICD-9 CM coordination and maintenance meeting in September. So I don't think that the idea is that everyone will have their own cross map, although I think the use case may drive the cross map as well because, for some use cases, you've got to put everything somewhere, and for others, you might take a different approach.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Nancy, this is Nancy Orvis. What I meant by that statement was that our people are looking at, we would rather just remap our – we collect many of these things already using other coding like medicine. We are looking at the fact that we would just probably rather do a direct mapping directly to the ICD-10 rather than take the ... from there to ICD-9 and then go to 10.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Yes. I feel like that's SNOMED to ICD-10 or....

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

We don't think it will be accurate if we do it the other way for the certain areas like in problem lists and that kind of encounter.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I appreciate that clarification.

Patricia Greim – VA – Health System Specialist: Terminology

This is Patty Greim from VA. Is it – do we agree that a single SNOMED to ICD-10 CM mapping would be a value for everyone?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think, again, within the context of meaningful use, I think that because those are both vocabularies or at least in the IFR for problem lists, I think, for that purpose, a single one would be extremely useful here.

Patricia Greim – VA – Health System Specialist: Terminology

I think that, to the extent that we could provide a single mapping from SNOMED CT to ICD-10 CM would be a place where we could really recoup a lot of value because every organization would not have to do that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

M

Yes.

M

And there's another dimension to that. I mean, from a provider perspective, conceivably if you use an internal map or some non-designated map, accusations of fraud and abuse for billing purposes could arise, whereas that, you're more or less indemnified if you're using the sanctioned map to go from SNOMED codes to ICD codes.

Clem McDonald – Regenstrief – Director & Research Scientist

Has anybody done such a mapping or begun such a mapping to see what the problems are?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Between SNOMED and ICD-10?

Clem McDonald – Regenstrief – Director & Research Scientist

Yes.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Yes. There's a lot of work that's been done. The problem is that we still don't have this final agreement between IHTSDO and WHO. We can just move it to its conclusion, and then we have to work on the map to ICD-10 CM.

Clem McDonald – Regenstrief – Director & Research Scientist

But has someone experimentally worked with them because some of the ICD-9 and ICD-10, they have many to one, I mean, you have two things bound together, which wouldn't show up in a natural code system. I don't want to say that wrong. I mean, it's diabetes with neuropathy, so what might be coded as two separate things in a problem list or in a SNOMED code become one, and so have people grappled with any of that? Some of that is required in the billing side. You've got to push it together.

Patricia Greim – VA – Health System Specialist: Terminology

Clem, this is Patty again. Even more reason that a single canonical map for the U.S. realm, SNOMED CT to ICD-10 CM, would be a value, incredible value.

M

And the work so far, Clem, has actually grappled with what I think Stan and I call the compositional problem when you're dealing with a many-to-many mappings. The problem is virtually all the consumers are clamoring for a one-to-one map, which for the reasons you just outlined, does not work. So at some level, we have to do some consciousness raising to clarify that one-to-one mappings are probably never going to work in a way that is even close to satisfactory for the community.

Clem McDonald – Regenstrief – Director & Research Scientist

Yes. I like that. We'll work at raising our consciousness.

Patricia Greim – VA – Health System Specialist: Terminology

Consciousness raising is great, and I think solution proposing is even better.

Clem McDonald – Regenstrief – Director & Research Scientist

Well, I mean, what we ought to probably be doing is doing some work on it now or somebody to understand the issues and try to come up with a good solution.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. This is Betsy. I think that as Marjorie said, there's been work done with plain vanilla ICD-10, and we will be using that work to try to do something with ICD-10 CM. We're working first from the point of view, the first piece of that is insertion of that in the UMLS for the synonymous mapping to SNOMED CT and for 10 CM—10 is already in there—and we are working on a version of 10 CM now in terms of insertion of it into the UMLS.

M

Anyway, Jamie, I would say I like the matrix. We may, you know, we talked about some tweaks here, but I like that as a basis, and so I would, yes, I would ... courageous to go on with your agenda here.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you. No, I appreciate that. I just did want to put it up for debate and see if it was useful. If this is a good, broad outline of the kinds of information that we want to get input on through hearings, and I think probably the next question is how to chunk that up or whether to chunk that up into one or more hearings. So, for example, one possible way to start would be, I mean, there are a couple of different ways to approach this, naturally.

One could be to take all the considerations for value sets and have measure developers and users of particular value sets and implementers all talk about what's needed for value sets and have that be just one hearing. Another approach might be to take it more at the functional level, and then a third approach might be to somehow combine those into different communities who would speak throughout the course of a one-day hearing, as an example. How do folks feel about the different possible approaches to getting input on this?

Clem McDonald – Regenstrief – Director & Research Scientist

I think we have trouble separating out those function content kinds of issues from a hearing perspective that, from an infrastructure delivery, those are so intertwined. I'd be inclined to go with, I think, what I read to be your or heard to be your more combined approach.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. That's what I was thinking is that what we'd like is people who have already worked on this or that have requirements to come and say, okay, now if we're going to maintain value sets, what do we need? That would be a mix, I think, of people who have thought about it, but haven't built things, and then some other people who actually have working systems that are doing this and can describe the capabilities of their system and what capabilities they have in the system.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let me throw an idea out then for a hearing that would have essentially four parts. The first section might be hearing from implementers and users of EHR technology on what they think their requirements are. The second part might be from EHR vendors. The third part might be from measure developers who are involved in meaningful use, in particular, with the value set issues around meaningful use. Then the fourth part would essentially be a reactor panel at the end of the day of folks who are providing this kind of infrastructure in the market.

M

Well, the group that's missing, Jamie, is the community of people that have actually built, engineered, and delivered terminology services, exactly what you're asking for.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I thought that was this fourth group?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, I thought that was sort of the reactor panel.

M

Maybe he labeled it vendors, and maybe he shouldn't have because they're not all vendors. They're open source and other contracted solutions that aren't necessarily vendors, but that's what you intended, right, in your fourth group is the people who are really offering these things.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Essentially, the idea of that proposal would be to get requirements from a few different perspectives and then hear both reactions to those requirements and hear what's already been developed from those who have done the work.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Let me ask another question, Jamie, which I think what comes later may, in terms of how we're thinking about our process, may be important for how we structure this input. Are we thinking that we or we would recommend because we don't make the final decisions, but we would end up making a recommendation that said we think ONC should contract with this vendor to do this or with this group to do this, you know, to provide value set functions for us, or that what we would do is end up providing more or less a comprehensive set of requirements that would then, it would be up to ONC to say whether they wanted to build it themselves or they wanted to....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. I think it's the latter. I mean, I think it's our job to recommend what we think the requirements for this functionality should be that should be fulfilled by ONC somehow.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Then ONC would just have the choice of whether to buy something or work with somebody to extend something or do it themselves or whatever they wanted to do.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That's my feeling. How do others think about that?

Patricia Greim – VA – Health System Specialist: Terminology

Jamie, this is Chris Brancato. I would agree with that submission. I think that's clearly consistent with what ONC is doing at this point.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

And I think that's the best approach as well.

Patricia Greim – VA – Health System Specialist: Terminology

I'll echo that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Now is this, I mean, I think that Clem made a good point earlier that this is a very broad set of topics. Is this something that we can expect to get input on in one hearing, or is this something that we might want to plan to stretch out over multiple days of testimony and discussion?

Patricia Greim – VA – Health System Specialist: Terminology

This is Chris. I'm obviously prejudiced, and I should disclose my biases. For those that don't know it, my group has been involved deeply in terminology services evaluation, so I have my prejudice. Nevertheless, I think that this is so fundamental to the infrastructure that ONC is seeking to propose nationally, and the topic is sufficiently complex that trying to do all of that, particularly the four groups that you enumerated, and have any reasonable overview of each of those four groups in a one-day session would be horribly compressed.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I would agree. If you just take those four groups of people and start making even the quick list that we could say right now of who would be interested, you're up to 20 or 25 groups minimum already without even thinking hard.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, I think that's good. Does anybody disagree and think that we ought to go for just one session?

Marjorie Greenberg – NCHS – Chief, C&PHDS

No, I definitely don't think one day would be adequate.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

If we're going to have multiple days, then I still would prefer, subject to your approach, but I still would prefer to have essentially requirements first, so requirements from end users, from implementers of EHR technology being in the provider care settings, and also from perhaps vendors, EHR system vendors who are selling the systems to those users. I think, I really do feel that users need to come first in terms of stating their requirements. And I think, Floyd, you have a particularly interesting and complex set of issues around value set management that will be required for the different quality and performance

measures for meaningful use, and I do feel that that's a topic that's worthy of a great deal of discussion. Does anybody disagree with essentially users and implementers first?

Betsy Humphreys – National Library of Medicine – Deputy Director

Jamie, this is Betsy. I don't disagree with that at all, but you know I am very persuaded by the level of issues and potential complexities around the measures, the quality measure developers, and I really wonder whether they should go first because I think that both the implementers and the users and the vendors probably need more education in the issue of measures, as well as anyone who would provide the value set service, you know, vocabulary of value set services. So I'm wondering whether they should go first.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Let me propose then that we could have a first day that would be the measure developer community around the value sets for meaningful use and essentially end user implementers and maybe have morning and afternoon, something of that nature.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd. Just as a comment, we did have a series of hearings where we did have some of these groups present. I think we want to be careful that what we ask them to talk about is more detail or more about the implementation itself and not just a repeat of the prior presentation.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Yes, exactly. I think, Floyd, we're not asking really about the process of measure development or the particulars about the measures, but rather, as you said, about the implementation and the requirements for infrastructure to get those out to the actual users.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. I like the way the meeting, as you framed it, Jamie, with the measures discussion first and then end user, user implementers.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Then we might have a second hearing, say, perhaps a month later, something of that nature, hearing input from both EHR vendors and terminology service experts and providers and vendors.

M

I think that's very sensible.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, I like that.

Clem McDonald – Regenstrief – Director & Research Scientist

Could we get some, somewhere along the line, out of this, some sense of the use, feasibility problems, successes that have happened in these spaces in order to get a sense of how difficult it is, how well it works, what are the issues, where it works well, where it doesn't, if we know that, if anyone, the people who have had the experience or any experience?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I would want to sign up to say exactly those kinds of things on behalf of Intermountain Healthcare and our experience here as an end user implementer.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think, Clem, that's a good question to add to all of the sessions, although I would expect to hear more about or a broader perspective on that on the second day versus the first day.

Clem McDonald – Regenstrief – Director & Research Scientist

I'm ... it's just be interesting to know what we really know in terms of when it works, where it works, what kind of volumes it works in. What are the abilities of institutions to deal with things other than making up things in three minutes because they need it for tomorrow and that kind of thing?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I agree, Clem. And that's why I think I was a bit abrupt when I was suggesting that the reactor panel, the way you initially described it, really didn't imply that people who have been grappling with this problem for a decade or more, and have really built things and, frankly, made errors and made mistakes, and know to some extent what works and what doesn't work. I think Clem is suggesting that there be a forum where the vendors not just react to those requirements, but, frankly, draw on experience that most of the users don't even appreciate are requirements when you get down to it.

Clem McDonald – Regenstrief – Director & Research Scientist

Yes. Here, here.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think we've started to talk about the questions that we want to ask our presenters to cover. Maybe there are a few questions that we could devise that are common across all of the different presenters, and maybe there are then some for the measure developers that are different from the end users and different from the EHR vendors and so forth. And it sounds as if one line of questioning that we might want to consider going across all of them is essentially what Clem just said. What's your experience? What works and what doesn't work?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Yes, I think that's really important because, as both Clem and Chris have pointed out, there's a great desire for this, and probably need for it, but it's not trivial, and so I think now we're really getting into the issues of implementation and what needs to be done to make this work, and is there generation one? Is there generation two? How ambitious should it start? All of those issues that have been raised, I think, will be very important for the workgroup to engage with people on.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

What else would be a line of general questioning that we might want to pose to all the different presenters?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I think we can just be a little more specific in asking where are you using value sets or subsets. How many sort of the domains, you know, are you using them in pharmacy, in lab? But even more specifically, you could say how many value sets do you have, and have you been maintaining them? And what is your maintenance process if you're doing that? How many people are involved? Just a lot of that kind of detail would be very helpful to give a scope and to help us start gauging the magnitude of what this may look like and how many people it may take to do this well at a national level.

Patricia Greim – VA – Health System Specialist: Terminology

And I think that is very important, Stan, and where can we leverage national effort to decrease the burden on individual participants?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let me just get back for a minute to what Stan mentioned about sort of what resources does it take. What are some of the different dimensions of that resource question? I think, Stan, you asked, how many people does it take for the domains that you're supporting in terms of value sets and subsets? What other questions or nuances might we ask about sort of what the resource requirements are for supporting these capabilities.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I don't know if everybody is organized the same way or how other people think about it, but I mean we have – you can think about you get clinicians involved because they are ultimately the people who know, you know, it's the people who are cardiologists or nurses on the floor or intensive care medicine doctors that know the real medical facts that these things ultimately depend on. And so how do you interact with the clinical experts to gain the knowledge? In our case, we have a team of terminologists, modeler/terminologist, that work with those clinical experts, and so it'd be interesting to know, you know, how many of those kinds of, if you will, sort of full-time or specialized modeler terminologists they have, how they interact with the clinical experts, and then a third category is people that are, well, there's usually also then some level of programming support in terms of either just things that will take, you know, load things from spreadsheets into the official tables, or you may be using, you know, I guess, if people are using commercial or open source software for this, you know, how many programmer sort of people do you need to install the software and keep it running and maintain databases. Sort of the programming resource, if you will, that supports that as well, so I'd see at least those kinds of three categories of resources that would be of interest.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't know whether this is, I guess maybe this isn't a set of questions for this particular group of people, but one of the things, I think it was Patty who said the issue is okay, well, if there are national value sets that are being disseminated in some timely and useful fashion, does that cut down on everybody having to do locally, and I guess we would, I mean, we're not. If it doesn't, for meaningful use, then we will have not done anything useful, obviously. But one of the things that occurs to me when I listen and talk to various people is that I think there may be no appreciation of, and maybe we're not the ones to do this education, but there may be no appreciation of the irreducible minimum that has to go on in the local system like where are you capturing the fact about on what day you implemented the new value set or, you know, something like that.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Or use the metadata, like when did you turn it on, and when is it active, and when is it inactive?

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Well, I'm just saying that, and I don't know whether it comes out in this set of hearings or not. It's just that I think that no matter how – I sincerely hope that we make this very easy or get to the point where it is. I sincerely hope where there are national value sets for these things that are required for meaningful and other similar things, and you can just get them, or your vendor can, and it's easy to put them in. But it still seems to me that we're always going to have the notion of, well, what day did this particular practice do X, or did this hospital do Y? And there is sort of an irreducible minimum of keeping track that has to be done at the local level.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Betsy, do you want us to make a point? I mean, I called out the metadata management piece and the code synchronization piece, and you can never not keep doing that, whether you're installing zip codes or anything else.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, but I think what I'm hearing is that there are sort of two sides to the same question of, in the first place, where can national resources be leveraged. And the other side of that is what is the irreducible minimum of local work at the implementation site.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Good point. I'm just doing an eight-year study showing what it is costing us to do synchronization of loading ICDs and CPTs, you know, like since 2001 and the fact, even if you get them three months ahead of time, do you still hit your internal implementation date because HHS committees or whatever, as they've made them available. Is that the kind of issue? That is the irreducible minimum, but no matter what, if you put them out in timeliness, does that still mean you can implement them in time? That's one of the issues.

Clem McDonald – Regenstrief – Director & Research Scientist

You just suggested something else about some of the systems, so I know that some places get their ICD-9 codes with other attributes like things about the appropriate diagnoses for a given test. I mean, they get a package.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Right. They buy some things commercially packaged.

Clem McDonald – Regenstrief – Director & Research Scientist

And the same is true, of course, with ... codes currently.

Marjorie Greenberg – NCHS – Chief, C&PHDS

And weight ... and everything else.

Clem McDonald – Regenstrief – Director & Research Scientist

And I guess we should ask if people who do that, would they change, or would they want to have, you know, I mean, how would they react, and what would we want to do to make their life easier?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Or are we saying that those vendors who do that packing for them will do it for them?

Clem McDonald – Regenstrief – Director & Research Scientist

Well, the question is, I guess the question is when you remind them of those things, do they still want to go to a central service? The second question is, could the central service accommodate the commercial kind of side of this?

M

You're getting into value add products and knowledge issues, Clem, which is how they make their market. I mean, at one level, it really begs who would be the customer of such a knowledge resource, the value set resource of the terminology services. I doubt very much that the small, you know, one or two physician practices are going to be the customer. I think large, academic medical centers, large centers will maybe be a direct customer. Another set of customers might be these commercial packagers. But,

frankly, it would be helpful if the commercial packagers were all singing off the same song sheet, and we had a canonical versioning and standard to point to that said this is what you should be using. Here's the data. Here are the value sets enumerated and available so that we all have the same page to even point to.

Clem McDonald – Regenstrief – Director & Research Scientist

I see, but I think that question, if we could stir it into the hearing might be good.

W

Maybe we need some of these people in the hearing.

Clem McDonald – Regenstrief – Director & Research Scientist

Yes, because, on the one hand, even in the larger organizations, the most senior people may not be aware of what's really going on, and they may think this is great because we'll just pull it off in the central server where they wouldn't. On the other hand, maybe there's some way, like you're pointing out, that we could make everything align better through the central service, going to these services.

W

Well, as I said, to me it suggests that we need to include certainly people who provide these services now, among those people that are talking to us.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

One of the other things I heard somebody mention is a question of, what is your maintenance process. Now how much detail do we want on that kind of thing?

Marjorie Greenberg – NCHS – Chief, C&PHDS

That seems like a pretty practical question, and I think, you know, we want our recommendations to be based in--

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

In reality?

Marjorie Greenberg – NCHS – Chief, C&PHDS

--reality, yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I guess at least I would think that would be one of the questions that would be a test.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I think a couple of more specific questions around that, you know, one general question is how do you know something needs to be updated? Do you wait until your users say there are things that I want to say, and they're not in the list? Do you have a team of people that, for instance, are watching, and either watching the literature or watching new measures that are released or new guidelines that are released and saying, if we're going to implement that, we need to update value sets to accommodate some new content, so do they have people who are proactively watching and updating, or is there maintenance basically, and an end user or somebody says, I can't do what I need to, and that prompts updates?

W

What about maintaining and every time there's a new version of the base...?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. That's a third way, and all of those point to a more general question is, well, it says okay, and then when you make changes, are you versioning your value sets? Do you track? What metadata do you track with changes then when you have to update the value sets? What's the metadata, and what's the versioning mechanism related to that?

M

Stan, I would agree with all of that, and I'd add an additional comment. When do you decide, especially in measurement when do you decide to implement the new version? For instance, you may update it every time there's a base standard update, but you may not implement it until the next year's performance, so how does one determine that?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes, I agree.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Good.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Now the other, this goes back to a question we asked earlier, and this, again, this is, I only know one story, so I ask about the things that I – you know, one of the questions I would ask is how do they make the connection between their value sets and where they're using them. How do they know which? How does an application know which value set it's used? Somewhere in your system, you have to have that knowledge to know this value set is used in this HL-7 message, and this value set is used in this rule. This value set is used in this application. And ask very generally how people know that information, how they know the connection between the value set and where it's used.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And how do you know the purpose of the value set?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes.

Clem McDonald – Regenstrief – Director & Research Scientist

I think Stan is asking about something more type than purpose. It's back to this question.... I think people who aren't in the business often think of these things as just they exist sort of out in the stars, and they're permanent, independent of the context, so it's really what fields, what message fields. Somewhere in the computer, where does it go? I may be overstating what Stan is asking.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

No. It's both things. I mean, we're not doing all this yet, so don't take this as – but our best guess about this is that you actually need something that says, in a human readable way, what your intension was, and then you need the other computable mechanisms. Somewhere, you actually have something that says, for instance, this value set is intended to be the set of routes of administration used in conjunction with version 2.x of an HL-7 pharmacy message. Then somewhere else, to actually support the software use, you've got something in your software that says, when I'm translating an HL-7 message, I come to this field.

I know now that that field has to have a value. You know, there's some token there that tells me this is the name of the value set, and I can go to a terminology server and determine whether the value that's in this message corresponds to a value that's in the value set that's been specified. So there's a need to say it in words because that allows permanence of the intent, and then you have those other ways where it would be interesting to know what people are doing to make that computable and understandable by the software so that you can actually validate messages by reference to the value sets that are supposed to be in use in that instance.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Got that. I've noted roughly a dozen questions so far. Just in terms of our general process, what I'm going to propose is that Betsy and I will take the input from this discussion today, come up with a revised version of the matrix and a set of draft questions, and then come back and have an additional call, our next call of the taskforce to refine our approach to the hearings before we go and have outreach with anyone, so that our next call might be a time to both refine the questions and to determine who our list of invitees might be.

M

It sounds like a plan, Jamie.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes, I think that's good.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let me just – I'm just thinking about some of the functions. One of the questions that we had spent some time on in earlier meetings was the degree to which downloads could be accomplished through Web links and just providing a link as opposed to having an actual repository, and I wonder if we should or to what degree we should revisit that question in this upcoming hearing.

M

I think that gets into lessons learned by the vocabulary services implementers because obviously that's an obvious approach, and I think it can be a question that you explicitly ask of the implementers, you know, what's wrong with that? I think I can anticipate the answer, but we're not having the hearings right now.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

Clem McDonald – Regenstrief – Director & Research Scientist

That question might go beyond implementers because other folks may have input or interest too. I mean, for example, yes, I think that's a good question across some of these groups, not just implementers.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. I'm wondering, Floyd, if I can put you on the spot again, and ask you from the perspective of the measure developers, are there a particular set of questions that you think we should either have or avoid for them?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think you've addressed some of the issue in the prior discussion, and that's why I added in when to actually make a version of a value set active for the measure. And I think we did hear from measure

developers in our first round about preferences for creation of them and some comment about how to handle proprietary issues. I guess we could ask some of that again. I'm not sure we'll get any different answers.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. I don't want to just revisit the same stuff or rehash, as you said, what they've already provided input on.

Clem McDonald – Regenstrief – Director & Research Scientist

I'm not sure what else at this point to add.

M

Yes. I'd actually caution that we leave the proprietary content issues out of the infrastructure discussions because it's a completely separate discussion.

M

I agree.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. Okay. What about other particular questions for end users or hospitals, medical groups, or other implementers of EHR technology?

M

I don't know if this is related to some of the other questions, but as far as implementations, where do they see value sets as providing input to clinical decision support, and how would they implement those and deal with versioning?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Any other questions for the end user? Should we differentiate between end users, actual clinician users versus implementers? Are there any particular functions for the actual clinician end users that we wanted to talk about?

M

What you might do is you might have more questions than you think any one particular responder might give, and say those to which are appropriate because you never which clinicians will think what way. People may not be as cubbyhole as we label them. You know, if you could sort of say, there are a couple of other questions. If they apply, or if you have some response, you may want to respond to too, instead of explicitly saying you guys answer these three, and you guys answer these three, although there may be some that would not make sense, except for the particular category.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Now in terms of EHR vendors, and EHR developers, are there any particular questions from their perspectives that we want to think about that we haven't already addressed?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

There's the added perspective now when you're in that role where you're essentially supplying multiple places. Then the question becomes how do you manage distribution of updates to multiple of your customers, basically?

M

That and how do you manage their local specializations, which is ... now?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. Absolutely. Yes, I guess an issue that we haven't raised is almost all of these things in real implementations, you have what comes from the standards, and then there's some flexibility for people to add local synonyms of local mapping that need to persist through updates that are coming from the central source and ask them about how they manage that.

Patricia Greim – VA – Health System Specialist: Terminology

Yes, Jamie. This is Chris Brancato. I'd like to echo what Stan and Clem said, but through a different lens, and that is, how do we certify those systems? This is a crucial question I think we need to get to the bottom of.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Chris, tell me a little more about that perspective. In terms of certification, how could this provide or how do you see this working in terms of providing input to the certification process?

Patricia Greim – VA – Health System Specialist: Terminology

Essentially what we'd be looking for is obviously everything derives from meaningful use and then certification criteria comes out of the standards and the expression of our meaningful use definitions. But I think one of the challenges here when we start to test vocabularies is, is the context right? Now only is the data element correct, is the optionality correct? But are you using it in context for meaningful use correctly? And that's a cat we're going to have to skin at some point in the near future.

Clem McDonald – Regenstrief – Director & Research Scientist

Could you give a specific example in terms of vocabulary? I mean, I know optionality in terms of messages and all, but you really brought this up in the context of what commonly happens is everybody has their own problem list vocabulary if they've made one up, and then they add codes to it just to get to billing or to get to whatever else they have to get to. In that context, could you give an example of where there'll be problems or where we should come in harder?

Patricia Greim – VA – Health System Specialist: Terminology

I think getting to it from just the challenges of certifying these things is do we expect a vendor to instantiate the entire vocabulary in their software?

Clem McDonald – Regenstrief – Director & Research Scientist

Yes. I think the rules say things like some percent. I guess the rules don't speak to that now, do they?

M

No, and the point is, do we make recommendations going further today that we expect them to express a SNOMED CT vocabulary in a certain context. Then obviously we would need to figure out a way to test that context.

Clem McDonald – Regenstrief – Director & Research Scientist

I guess I'd suggest that might be getting out of what we can talk about in our goals of trying to make a repository, but I don't know what other people think.

Patricia Greim – VA – Health System Specialist: Terminology

No, I think you could be right there, Clem. But I guess what I'm getting at is do we ask the vendors a question of what their intentions are. Clearly, meaningful use definition standards and certification has

presented a signal to the industry that they would have to reconcile the vocabularies that end up in the regulations. But I'm wondering whether or not that's a fair question we ask the industry today is how do you intend to get your products certified knowing that these new code sets and terminologies end up as part of regulation.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd with a comment, Chris. I think, if we go back to one of Stan's comments, so it's not just the values, but the context of use, so if there were some way to ask a vendor how they deal with the data model to identify the context of use, that may be outside of the scope of the current discussion, but that might be one way to approach it.

Patricia Greim – VA – Health System Specialist: Terminology

Just wanted to throw that out there, I guess, as a point of enlightenment. But the other point is asking the question whether that's a fair question in this context. It sounds like the answer is no.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, but I think one way we might approach that is getting back to an earlier part of your comment, Chris. The question of what has to be local in EHR implementations versus referred to in an external repository.

Patricia Greim – VA – Health System Specialist: Terminology

You said it better than I did, but, yes, that's where I was going.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Then what questions have we not addressed yet that would be particularly relevant for terminology service developers?

Clem McDonald – Regenstrief – Director & Research Scientist

I think the obvious question is what do those people think the actual requirements and functionalities are that, in their experience, users have not appreciated, and maybe examples of where that made a difference.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Good. At this point, I've got about 15 questions that I've noted down, and I'll take a crack at organizing them, perhaps rephrasing them. I'll get it out to the group. Betsy, unfortunately, has lost her phone connection, so is not going to be with us for the rest of the call. I'm wondering if folks have other ideas for questions. I'd love to take them now. Otherwise my thinking is, we could call an end to this particular meeting a little bit early, a half an hour early, and then come back and continue this discussion in our next call. How does that sound?

Clem McDonald – Regenstrief – Director & Research Scientist

Sounds good to me.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes, sounds good to me. Is there a public comment part of this?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, there is.

Alison Gary – Altarum Institute – Communication Technologies Coordinator

I'd be happy to give the directions for that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Sure. If you could please do that, is that Alison?

Alison Gary – Altarum Institute – Communication Technologies Coordinator

Yes. We have one public comment.

Operator

Lee Stevens, your line is live. Please state your name and your organization.

Lee Stevens, IGA Policy Advisor, Office of Programs & Coordination

My name is Lee Stevens. I'm listening on behalf of the Food and Drug Administration. I just wanted to make the group aware that I was listening in. I'm a member of the FDA data standards council, and there were some questions about your group in terms of what specifically you were working on and your work products, and how our agency could make use of your work products. So I just wanted to just, again, just inform people that I've just been listening in on your conversation, and it sounds encouraging and FDA will try to participate and provide comments and feedback to your work in terms of how we can potentially make use of your work products.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That's great. Thank you very much, Lee.

Alison Gary – Altarum Institute – Communication Technologies Coordinator

We don't have any other public comments.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Then I think we're ready to declare an end to this call. Thanks, everybody, very much for your time today. I truly appreciate it. For those of you who are on the standards committee, I will see you tomorrow.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Great. See you tomorrow.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you.